South Carolina Department of Disabilities and Special Needs

Initial Report of Alleged Abuse, Neglect or Exploitation (ANE)

This form is to be completed based on Reporting Requirements outlined in Attachment A.
One report should be used for incidents where the type abuse is the same for all victims/all perpetrators.
In alleged incidents involving multiple victims/multiple perpetrators where the type abuse is different,
a separate report must be submitted for each victim/perpetrator (i.e., not combined into one report).
Reviews and addendums should be submitted as indicated above.

Direct Call Made to SLED (if applicable): ☐ **Yes** ☐ **No** | **Direct Call Made to DSS** (if applicable): ☐ **Yes** ☐ **No**

Provider:

Victim(s) Name(s): (attach add'l sheets if necessary)	*DOB:*	*Age:*	*Sex:*	*Race:*	*Was consumer enrolled in the DDSN Waiver when incident occurred?*	*If yes, specify which waiver: (MR/RD, HASCI, PDD, etc.)*
1.					☐ Yes ☐ No ☐ Don't Know	
2.					☐ Yes ☐ No ☐ Don't Know	
3.					☐ Yes ☐ No ☐ Don't Know	
4.					☐ Yes ☐ No ☐ Don't Know	

Residence of Consumer(s): ☐ Family/guardian home or own home ☐ CRCF ☐ CTH I ☐ CTH II ☐ ICF/MR ☐ SLP I ☐ SLP II ☐ Other (i.e., boarding home) ☐ Unit @ Regional Ctr (ICF/MR)

Descriptive Location of Residence: (i.e., family home, own home, Jim Doe CTH I)

Disability: ☐ MR ☐HASCI ☐ Autism Related Disabilities _____

Communication Level: Verbal Other Means (list):

PERSONS INVOLVED: (attach additional sheets if necessary)

Alleged Perpetrator(s): Perpetrator/Title (Victim 1): Perpetrator/Title (Victim 2): Perpetrator/Title (Victim 3): Perpetrator/Title (Victim 4):

Primary Witness: _____ Title: _____ Initial Reporter: _____ Title: _____

Other Witness(es): _____ Title: _____

Title:

INCIDENT:

Type Location of Incident: *DDSN Contracted Provider:* ☐CRCF ☐ CTH I ☐ CTH II ☐ICF/MR ☐SLP I ☐SLP II ☐Day Service ☐Other *DDSN Regional Center (ICF/MR):* ☐

Descriptive Location of Incident (i.e., family home, own home, Jim Doe CTH I):

Date of Incident:	Time Incident Occurred: ☐ AM ☐ PM	☐ Date of Incident Unknown
Date Incident Reported:	Time Reported: ☐ AM ☐ PM	Reported to Whom (Name & Title):

Description of Incident *(brief summary only):*

Type of Suspected Abuse: (Check all that apply) ☐ Exploitation ☐ Neglect ☐ Physical ☐ Psychological ☐ Sexual

Nature & Extent of Injury/Harm to Victim: _____

Safety Plan for Victim or Others at Risk: _____

Referred for medical exam? ☐ Yes ☐ No If yes, Date _____ Time _____ ☐ AM ☐ PM Photographs taken? ☐ Yes ☐ No

Evidence preserved? ☐ Yes ☐ No

Personnel Action Taken: ☐ Administrative Leave W/Out Pay ☐ In-Service Training ☐ Legal Charges ☐ NA/No Staff Involved ☐ None ☐ Resignation/No Longer Works for Agency ☐Terminated ☐ Transferred ☐ Unknown ☐ Verbal Reprimand ☐ Written Reprimand

NOTIFICATION:

☐ SLED: Name: Intake # & Case #: Date

☐ Law Enforcement: Name: Date:

☐ DSS: Name: Date:

☐ DHEC-Health Licensing: Name: Date:

☐ Parent/Guardian/Primary Correspondent: Date: Time: ☐ AM ☐ PM

(Address): Phone:

(City/State/Zip)

SIGNATURE:

Executive Director/ CEO/ Facility Administrator (or Designee for Executive Director/ CEO/ Facility Administrator)	Date	Name of Person Completing Form

Send completed form within 24 hours or the next business day in which the suspected abuse, neglect, or exploitation is discovered to:

- Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX #: 803.898.7450,
- SLED (for alleged abuse, neglect or exploitation involving vulnerable adults), FAX #: 803-896-8050
- DSS (if applicable)